IN THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT
OF THE STATE OF FLORIDA IN AND FOR HILLSBOROUGH COUNTY
CIVIL ACTION DIVISION

FLOYD J. KENYON, SR. and FLORENCE
KENYON, his wife,
Plaintiffs,

Case No. 00-5401
-vs- Division: "D"
R.J. REYNOLDS TOBACCO COMPANY, a
foreign corporation,

Defendants.
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TRANSCRIPT OF PROCEEDINGS

BEFORE: THE HONORABLE HERBERT BAUMANN
Circuit Judge
TAKEN AT: Courtroom Number 1
Hillsborough County Courthouse
Tampa, Florida
DATE: 20 November 2001
TIME: Commencing at 9:20 a.m.
REPORTED BY: Mary Elizabeth Blazer, RPR
Notary Public, State of Florida

STENOGRAPHICALLY RECORDED (ORIGINAL)
COMPUTER-AIDED TRANSCRIPTION (COPY)

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ALSO PRESENT:
FLOYD J. KENYON, SR. (Plaintiff)
FLORENCE KENYON (Plaintiff)
DAN DONAHUE (Corporate Rep. of R.J. Reynolds)
DAVID DAVIS (Corporate Rep. of R.J. Reynolds)
RICK STUHAN (Corporate Rep. of R.J. Reynolds)
CHARLES WRIGHT (Technical Expert - R.J. Reynolds)

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(9:20 a.m.) P R O C E E D I N G S

THE BAILIFF: All rise. Circuit court is now back in session.

THE COURT: You may be seated.

MR. ACOSTA: Thank you, Your Honor.

MS. PARKER: Before we bring the jury in, I've got just a few matters.

THE COURT: All right.

MS. PARKER: If I may.

Your Honor, we have a pending motion in limine on this witness. This is one that Your Honor said that you would reserve ruling on. If I could approach and give Your Honor a copy. This just goes to his qualifications. I wanted to bring you another copy to ask if I could be permitted to voir dire the witness both on qualifications and on the underlying facts and of his opinion before Mr. Acosta gets into the opinion.

THE COURT: All right. After you go through the -- his qualifications, I normally do permit it if there's a request by counsel to permit voir dire. I'll permit that. And then when we get -- after that we'll -- before -- I'm not quite -- we'll get through

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that qualification process and then we'll see what types of factual issues there are.

MS. PARKER: We can just approach?

THE COURT: Yeah, you can approach or we'll go from there, okay, Mr. Acosta.

MR. ACOSTA: Yes, sir, that will be fine.

MS. PARKER: And the second thing is I just wanted to confirm that this witness understands Your Honor's instructions about not mentioning the biopsy or the test from last week.

MR. ACOSTA: I hope he does. I have talked to him and instructed him.

THE COURT: All right. Very good.

MR. ACOSTA: I can't do anything more than that.

MS. PARKER: Thank you, Your Honor.

THE COURT: All right.

Are you all ready?

MS. PARKER: Yes, Your Honor.

THE COURT: Mr. Acosta, are you ready?

MR. ACOSTA: Yes.

THE COURT: This is Dr. Goldman; is that correct?

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MR. ACOSTA: Yes.
THE COURT: As soon as we find Kenny, we'll get the jury in here.
MR. ACOSTA: We have radiographic films we are going to present to the witness that I had assumed we had previously stipulated that they -- and the pathology materials and the medical records were all admissible. They haven't actually been pre-admitted by identifying a particular film. What I was planning on doing -- and for the most part these are going to be demonstrative any way, but they are of Mr. Kenyon, so --
MS. PARKER: I probably wouldn't have any problem. If I could just have Mr. Yarber look at them -- just look at them to make sure the seem --
THE COURT: Go ahead and do that.
THE BAILIFF: All rise.
(Thereupon, the jury returned at 9:27 a.m.)
THE COURT: You may be seated.
Good morning, ladies and gentlemen.
I hope everybody is good this morning. Good to see you all back?

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JUROR #1: Can we not have our notepads?
THE BAILIFF: I got them. I kept them.
THE COURT: All right.
All right. The finest bailiff in the courthouse is just a little behind schedule this morning. He will be retrieving your notepads. In the meantime, I'm going to ask Mr. Acosta, we're going -- we broke on Mr. Kenyon yesterday, but we do have another witness to present. So we're shuffling the order a little bit. We will conclude Mr. Kenyon's testimony. But who is your next witness?
MR. ACOSTA: Your Honor, the plaintiffs' next witness is Dr. Allan Goldman.
THE COURT: Okay. Do you know --
MR. ACOSTA: He's in the waiting room over there.
THE COURT: Okay.
MR. ACOSTA: I'll be happy to go get him if you would like.
THE COURT: All right. If you'll do that, Mr. Acosta.
Very good. It's always important to

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keep Kenny on his toes.
Mr. Acosta has gone to get the next witness.
THE BAILIFF: Come on now. He was right there, I told him to hold on a minute.
(Pause)
THE BAILIFF: Watch your step, there's some wires, okay?
THE CLERK: Raise your right hand.

Thereupon,

DR. ALLAN GOLDMAN,

was called as a witness and, after having been first duly sworn/affirmed to testify the truth, was examined and testified as follows:

THE WITNESS: Yes.
THE BAILIFF: This way, please.
THE CLERK: Please watch your step.
THE BAILIFF: Yeah, please watch your step.
THE COURT: Mr. Acosta, you may inquire.
MR. ACOSTA: May it please the Court.

DIRECT EXAMINATION

BY MR. ACOSTA:

Q. Good morning, Dr. Goldman.

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A. Good morning.
Q. Would you please tell the jury your name and professional address?
A. Sure. Dr. Allan Goldman, 12901 Bruce B. Downs Boulevard, Tampa, 33612.
Q. And would you tell the jury what your occupation is?
A. I'm a physician.
Q. And can you tell the jury what kind of physician you are?
A. Yes, I specialize in what's called pulmonary disease, which is lung diseases and that's a subspecialty of internal medicine which is basically diseases of adults.
Q. Doctor, the microphone is not connected to a PA system.
THE WITNESS: Okay.
THE COURT: It's connected to the court reporter. The microphones are to help the court reporter.
THE WITNESS: So I don't need to speak into it?
BY MR. ACOSTA:
Q. No, it might be a little hard on her ears too if you do that.

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A. Thank you, sir.
Q. So, would you tell the jury what your educational background is?
A. Yes, I went to college, university -- at the University of Minnesota. I subsequently went to medical school at the University of Minnesota in Minneapolis, Minnesota. And then subsequently did what's called an internship at UCLA, at the Wadsworth VA Hospital in Los Angeles. Then did an internal medicine residency at the Brook Hospital at San Antonio Texas. Followed by specialized training in pulmonary disease or lung diseases at Walter Reed Medical Center in Washington D.C.
Q. What does the term pulmonary mean?
A. Basically lung.
Q. And what did you -- did you wind up at USF?
A. Yes, after spending some additional time at Walter Reed, I came to USF, which had a new College of Medicine. I arrived in 1974 to start a new pulmonary division or division of lung diseases at the medical school at the University.
Q. And are you still at the University of South Florida?
A. Yes, I am.

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Q. Can you tell the jury what positions you've held at USF?

A. Well, I was chief of the pulmonary division. And then that got expanded to the pulmonary and critical care medicine. And eventually also occupational medicine division. Rose through the ranks from an assistant professor to an associate professor, and professor.

And then most recently I have become what's called chairman of the Department of Internal Medicine, which includes all of the subspecialties of internal medicine, including lung disease, heart disease, kidney disease, intestinal diseases, et cetera.

Q. And are you affiliated with any of the local hospitals?

A. Yes. I'm on the staff of Tampa General Hospital. The James A. Haley VA Hospital, Moffitt Cancer Center, one called Kindred Hospital. And on the -- what's called the emeritus staff at University Community Hospital.

Q. Have you ever maintained offices at any of these hospitals?

A. Well, I had offices actually at the VA Hospital, at Tampa General Hospital, at Moffitt

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Hospital.
Q. And where is your main office?
A. At the University.
Q. And do you maintain a clinical practice?
A. Yes, I do.
Q. And for how long have you maintained a clinical practice?
A. Well, since arriving here in 1974.
Q. And what kinds of patients do you see in your clinic?
A. My clinic I see predominantly patients with lung diseases, of various sorts.
Q. Now, are you board certified in any particular specialty?
A. Yes. I'm board certified in internal medicine, and then board certified in the subspecialty of the pulmonary disease. And then I had what was called a certificate of added qualifications in critical care medicine.
Q. And can you tell the jury what critical care medicine is?
A. It would basically be intensive care, intensive care unit diseases that you see in adults in that unit. Usually the medical or non-surgical

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diseases.
Q. Do you supervise other physicians --
A. Yes.
Q. -- in your role?
What kinds of physicians do you supervise?
A. Well, right now as chairman of the Department, I supervise a faculty of about 200 physicians. I supervise residents, either in internal medicine or the various subspecialties of about 150 residents. When I was in pulmonary, I supervised the group of pulmonary physicians which ranged from usually 6 to 12. And the subspecialty residents or trainees which was also ranged between 6 and 12.
Q. Now, in addition to that, do you have your own patients?
A. Yes.
Q. And do you care for patients on a daily basis?
A. Pretty much, yes. Less so now because I have of a lot of administrative and supervisory responsibilities than I did for, you know, the last 25 years or so.
Q. Now, have you published any articles in

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peer reviewed journals?
A. Yes, I have.
Q. Can you give us some idea of the number of publications that you've worked on?
A. Well, I think in -- in journals approximately 65. Also some books and audio visual programs, what we call abstracts, probably another 40 or so.
Q. Have you published journal articles on the subject of cigarette smoking and health?
A. Yes, I have.
Q. Can you give us a summary of -- of those articles?
A. Well, one of my early interests was in the area of healthy effects of smoking, of carbon monoxide, from cigarettes, also cigars and pipes. And did some studies and published some articles and made some presentations about that.
And also lung cancer, in that area.
Q. Are you familiar with the term epidemiology?
A. Yes.
Q. Can you tell the jury what that is?
A. Well, epidemiology would be a field or specialty where you use a variety of methods, usually

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in groups, large groups of people, large studies. Studying various factors, trying to determine either causes of diseases or -- or courses of diseases or treatments of diseases.

Q. Are causes of diseases determined that way?

A. Yes. (Nods head)

Q. Now, do you review articles or publications written by other physicians?

A. Yes, I do.

Q. Can you tell us what your role is in that regard?

A. Well, in fact the term he used earlier, "peer review" means basically that when an article is received by a journal, they send it out to other people in that field to review it for its methods and its accuracy, and so on, to be sure that, you know, it's a well done study, and ought to be published in a journal. A lot of different people review those articles. I'm one of those who does that.

Q. Now, have you served on any national committees or boards with respect to occupational disease?

A. Yes, I have.

Q. And can you tell the jury what -- what

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national groups you've been involved with?
A. Well, in occupational disease I was mainly involved with the American College of Chest Physicians which publishes a journal called Chest. I was on the Occupational Lung Disease Steering Committee of that group. I was also involved in the American Thoracic Society with a committee or group that reviewed and wrote up an article on -- on asbestos related lung diseases.
I subsequently was asked and wrote some articles for the journal Chest and some of their continuing educational activities. We've put on some courses for those organizations in the area of occupational lung disease. Also the American Medical Association, as well.
Q. Have you had anything to do with criteria for determining whether or not something is a lung disease, such as asbestosis?
A. Yes, as I mentioned one of the assignments, if you will, was to review asbestos related respiratory problems and make up a paper, along with a panel of experts that were basically diagnostic standards for asbestos related diseases that subsequently was published in the American Review of Respiratory Disease.

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Q. Now, can you tell the jury -- or at least give some sort of estimate how many patients you have actually treated or been significantly involved in their treatment since 1974?
A. Sure. Really been involved in treating patients with lung disease for -- since 1970, so over 30 years, would be thousands and thousands and thousands of patients.
Q. All right. In your treatment of those patients, are you involved in cigarette smoking issues?
A. Well, in lung disease, one of the major causes of lung disease is smoking.
MS. PARKER: Objection, Your Honor.
THE COURT: I'll overrule. Go ahead.
THE WITNESS: Is smoking related diseases. I've certainly seen patients, many of the patients who we see who have lung disease, are or were smokers, many of them were current smokers at the time. So really again thousands of patients.
BY MR. ACOSTA:
Q. And do you counsel patients about smoking?
A. Sure.

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Q. And what -- what do you generally counsel them?

A. Well, we -- we try to get patients, if they're still smoking and we see them, we obviously try to get them to discontinue smoking. We've -- sometimes give them advice on different aids to try. Years ago they were prescription and we would prescribe those aids. Now they're non-prescription, generally. Direct them to various smoking cessation programs, and vast run some smoking cessation programs, and so on.

Q. Did you -- can you tell the jury about the -- the smoking cessation programs that you've been involved in at USF?

A. Well, we ran one at the VA Hospital where many of the patients were heavy smokers. And we had a lung disease ward or pulmonary ward where we had inpatients with lung disease. Many of whom were still smoking in spite of their lung disease. And we had a structured inpatient smoking cessation program trying to help them quit. And I served -- set it up basically.

Q. And what happened to that program?

A. Well, it wasn't very successful, unfortunately. It had use of psychologists, and I

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recall I think a psychiatrist, group sessions and so on. It was very difficult to get people to quit smoking. And this was really back in the mid to late '70s, and really was not very successful. The -- actually the psychiatrist, psychologist, got sort of depressed about the results being so bad, and didn't feel it was worth the time and effort because they weren't very successful in getting people to quit, so it basically fell apart.

Q. Did you supervise the psychiatrists and psychologists?

A. Well, I wouldn't say supervised, I set up the program, got them involved, and helped with it and all. We were -- I wouldn't say I supervised them. As I say they were independent.

Q. Now, why was it difficult to get people to quit smoking?

MS. PARKER: Your Honor, I think we're getting into opinion at this point.

THE COURT: All right. I'll -- I'll sustain for the moment. Is -- is there anything further on qualifications?

MR. ACOSTA: Yes, Your Honor, I have a few more questions on that.

THE COURT: Okay.

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BY MR. ACOSTA:
Q. Dr. Goldman, do you treat patients for nicotine related problems?
A. Nicotine addiction, continued smoking leads to a variety of lung diseases, cancer, what we call chronic obstructive lung disease, so in that context, certainly.
Q. And do you treat these addictions on a daily sort of basis?
A. Best I can. It's pretty difficult to treat addictions, but I try.
Q. Do you diagnose the addictions?
A. Yes.
Q. And is there any particular specialty that you refer any of the nicotine addiction patients out to?
A. No, not really.
Q. Why not?
A. Well, I've already said it's very difficult. We've tried that approach. If they're at the VA we sometimes periodically try again smoking cessation group clinics. Usually primary care physicians or pulmonary physicians try to help patients discontinue smoking by talking, education, advising them about what aids to use, various group

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programs available. I don't believe referring them anywhere else is -- it's costly, it doesn't really add much to the effectiveness, it's not something that we do.

Q. Do you prescribe medications for nicotine addiction?

A. We don't normally now a days they're really over the counter, various nicotine replacement things. There's still some drugs that you can prescribe, but generally the nicotine replacement is now non-prescription.

Q. In the past, did you prescribe medications for nicotine addiction?

A. Sure. And still do on occasion.

Q. And as part of your training and education, are you trained and educated to recognize people that are dependent upon nicotine?

A. As well as other substances, yes.

Q. What other kinds of substances are you trained to recognize and treat?

A. Well, I mean, through the years I've recognized and treated in the intensive care unit, alcohol related problems is a very common problem. Heroin, cocaine, prescription pain killers, prescription anxiety drugs, et cetera.

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MR. ACOSTA: Your Honor, at this time I would tender Dr. Goldman.

THE COURT: All right, thank you. Voir dire?

MS. PARKER: Thank you, Your Honor.

May it please the Court.

Good morning ladies and gentlemen.

VOIR DIRE EXAMINATION

BY MS. PARKER:

Q. Good morning, Dr. Goldman.

A. Hi.

Q. We've met before? You know who I am. I'm Stephanie Parker, you know I represent R.J. Reynolds?

A. Yes.

Q. I would like to ask you first some questions about your qualifications.

A. Yes.

Q. You agree that no one -- no doctor is an expert in every medical specialty; correct?

A. Correct.

Q. And that's why, for example, with Mr. Kenyon, he was treated by a number of different types of doctors; correct? For example, pathologists and radiologists and such?

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A. Sure.
Q. Okay. And you are not an oncologist; correct?
A. Correct.
Q. And you are not board certified or board eligible in oncology; correct?
A. Correct.
Q. And we talked a little bit yesterday about pathologists, about the doctor that look at the tissue under the microscope, you're not a pathologist, either; correct?
A. Correct.
Q. And you're not board certified in pathology?
A. No.
Q. Now radiologists is the doctor who looks at x-rays or CT scans. And you're not a radiologist either; correct?
A. Correct.
Q. And you're not board certified or board eligible in radiology; correct?
A. Yes.
Q. And in fact, as a -- as a pulmonary physician, you would never sign a radiology report, correct?

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A. Well, in fact, many pulmonary physicians do in their office. A member of radiologists sees x-rays of every organ of the body where the pulmonologist sees just lots of x-rays of the lungs and in many respects is highly qualified to interpret x-rays of the lungs, not of the stomach or the bones or things like that. Many pulmonary physicians in their offices actually do x-rays, sign the reports, that's fairly standard. (Nods head)

Q. I want to ask --

A. We don't in our practice because of the way we're organized.

Q. I want to ask about you. None of these hospitals that you listed where you have privileges, in none of those hospitals, do you sign radiology reports, correct?

A. That's correct. Right.

Q. And you're not board certified in psychiatry; correct?

A. Correct.

Q. Or psychology; correct?

A. Correct.

Q. And you don't hold yourself out as an expert in the field of substance abuse or addiction in general, correct?

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A. Well, what do you mean, in general? I certainly see more nicotine addiction than say a psychiatrist ever would. I wouldn't consider that I see some other addictions on a chronic ongoing basis that they would see.

Q. You've not passed a board on addiction in medicine, correct?

A. We don't have one in internal medicine that I'm aware of.

Q. You weren't -- you're not aware that the American Society of Addiction Medicine does have a certification?

A. We don't in our specialty of internal medicine and pulmonary disease.

Q. And you're not certified -- you're not certified in that area that we've just been talking about with the American Society of Addiction Medicine; correct?

A. No, I'm not.

Q. And you're not a member of the American Psychiatric Association; correct?

A. Correct.

Q. Or the American psychological association; correct?

A. Correct.

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Q. And you have no publications in any peer reviewed journal on dependence or addiction; correct?
A. No, that's correct.
Q. And you've never had any involvement or any role with any public health organization, like the American Cancer Society in terms of preparing brochures to give to doctors or patients on how to quit; correct?
A. Not with the American Cancer Society, no.
Q. Now, pharmacology is the branch of medicine that deals with the effects of medicines in the body; correct?
A. Well, drugs, medicines, chemicals, et cetera.
Q. And you're not board certified in pharmacology; correct?
A. No.
Q. And you've done no research involving the pharmacology of nicotine; correct?
A. No specific research, no.
Q. And you've never written anything on the pharmacology of nicotine; correct?
A. No.

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Q. That's correct, isn't it?
A. Yes.
Q. Yes, okay.
And you don't know the mechanism of how nicotine affects the brain, correct?
A. Well, I know in generalities the mechanism, I don't know if anybody knows specifically mechanism of anything at the cellular level.
Q. Well, that's beyond your area as a pulmonary physician; correct?
A. No. I mean I know it affects the dopamine system of the brain, which is all I need to know for my expertise in -- since I'm a physician and MD, not a pharmacologist, treating patients with nicotine addiction, I don't need to know the cellular effects to do that.
Q. And so you acknowledge that you do not know the cellular effects?
A. I don't believe anybody does.
Q. And you don't hold yourself out as an expert in carcinogenesis, and by that I mean what causes cancer?
A. I don't believe anybody knows what causes cancer.
Q. You don't hold yourself out as an

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expert in carcinogenesis; correct?
A. I'm not a molecular biologist. We're still learning at the cellular level the specific causes of these things, even though we know in general what causes it. But at the cellular level we certainly -- I don't hold myself out to be that, no.
Q. And you've never published any article in any scientific literature or any book on carcinogenesis or oncogenesis, correct?
A. Correct.
Q. And this research that you told us about that you've done on smoking and health, that was done in the 1970s; correct?
A. Well, I think some of the lung cancer ones were -- were subsequent. I have to look at the exact date. But I believe that was in the eighties.
Q. The article that you have referenced --
A. Uh-huh. (Indicating affirmatively)
Q. -- that you published was in the 1970s; correct?
A. No, I believe -- let me look up the date on the others here.
I believe that in 1992 I published one in the Journal of the National Cancer Institute on Environmental Tobacco Smoke and Lung Cancer Risk in

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Non-smoking Women.
Q. That's what's call environmental tobacco smoke. Let me ask my question again. I'm talking about people who are smokers.
A. Uh-huh. (Indicating affirmatively)
Q. The research that you have published on people who are smokers, all right. That was in the 1970s, correct?
A. Mid to late seventies, some of that, yes.
Q. And you've never conducted an animal carcinogenesis study correct?
A. No, that's correct.
Q. Now, I want to change subjects and ask you a few questions now about the underlying facts and data of your opinions that you have here.
A. Okay.
Q. Now, when you testify as an expert you like to review everything that you can about the case; correct?
A. Everything that's available that I have access to; correct.
Q. Okay. And you were -- you were not one of Mr. Kenyon's treating physicians; correct?
A. Correct.

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Q. And you formed your opinions in this case without ever having talked to any of his treating physicians; correct?
A. Correct. I see their reports, if you will, and the medical records.
Q. So you have their records but you haven't actually talked to the doctors; correct?
A. Correct.
Q. And you formed your opinions in this case without ever having had discussions with anyone about the radiology; correct?
A. Well, I considered myself quite expert at reviewing chest radiology myself.
Q. But my question is: You formed your opinions in the case without having discussed the radiology with anyone; correct?
A. I would hardly ever discussed the radiology with anyone else. I would rarely need that.
Q. And you didn't do so here?
A. I wouldn't hardly ever do that. It's not necessary.
Q. And you also formed your opinions in the case without ever having talked to anyone about the pathology in the case; correct?

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A. Well, I reviewed the pathology. I'm quite competent at reviewing lung pathology, especially lung cancer.
Q. But my question is: You formed your opinions in the case without ever having talked to anybody about the pathology; is that correct?
A. Yeah, I would see no need to do that. I would not normally do that unless there was some problem or question.
Q. And you formed your opinions in the case without having talked to anyone about the Pulmonary Function Test from Mr. Kenyon; correct?
A. Same response. I'm quite capable of doing that. I don't need to discuss that with anybody.
Q. Okay. But you did have discussions with Mr. Kenyon's lawyer, Mr. Acosta, about the case; correct?
A. Well, I got some more detailed smoking history from Mr. Acosta. I don't believe I discussed radiology, pathology, pulmonary function tests, et cetera.
Q. With Mr. Acosta?
A. Right.
Q. All right. And you formed your

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opinions in the case without ever having talked to the patient, Mr. Kenyon; correct?

A. I had not seen him as a patient, correct.

Q. Okay. And in fact you've never communicated with Mr. Kenyon in any way whatsoever; correct?

A. Correct. (Nods head)

Q. And similarly you formed your opinions in the case without ever having talked to his wife, Mrs. Kenyon; correct?

A. Yes.

Q. So am I correct that other than Mr. Acosta, you've never had any discussions with anyone about Mr. Kenyon's medical condition; correct?

A. I have adequate medical records that give me what I need. The x-rays and pathology and pulmonary function tests speak for themselves. They are the same if I look at it or somebody else looks at it there's really no need to discuss those things with anybody. I would -- I don't recall hardly ever doing that. I get sent patients all the time and I don't go over to x-rays -- I mean, I constantly see patients in consultation. I would rarely, if ever, go over the x-rays with the radiologist, the

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pathologist, with the pathologists, pulmonary function test with anybody. I'm quite capable of doing all that myself. That's standard practice.

Q. Well, just in terms of what you did here --

A. Same as I do when I see a patient.

Q. So you didn't talk to anybody except Mr. Acosta; correct?

A. I didn't talk to Mr. Acosta, except to relay more detailed smoking history that apparently was in depositions than was available in the medical records that I reviewed. I don't believe there was anything else that we discussed.

Q. Well, you formed your opinions in the case without reviewing Mr. Kenyon's deposition; correct?

A. Well, I asked for additional information about the smoking history, which Mr. Acosta relayed to me.

Q. Okay. But you didn't review the deposition in the case; is that correct?

A. No, that's correct. I understand they were seven hours in length. I didn't think that would be visible.

Q. And you don't know anything about

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Mr. Kenyon's work history; correct?
A. Well, I know a little bit. I again was not aware of any significant other exposures.
Q. So you know in your words a little bit about his work history. And you recall I took your deposition in the case. At the time I took your deposition you didn't even know whether Mr. Kenyon was or was not on oxygen; correct?
A. Well, invariably he's on and off. I think as I told you most recently he had been on oxygen.
Q. And you have no personal knowledge about Mr. Kenyon's smoking history other than what Mr. Acosta has told you; correct?
A. Well, I have the information that is in his depositions.
Q. You've not read those depositions though; correct?
A. As I said there's seven hours. I certainly won't read that when it's something somebody could tell me in a few minutes. That's correct.
Q. So it's correct that you have no personal knowledge about Mr. Kenyon's smoking history; correct?

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A. Well, when you say personal knowledge, did I watch him smoke? No.
Q. And you don't know why he started smoking; correct?
A. Well, I don't know why anybody starts smoking except that's the thing to do.
Q. I'm sorry. I'm sorry, I didn't mean to interrupt you. Are you finished with your answer?
A. Yes, uh-huh. (Indicating affirmatively)
Q. And you don't know how he quit when he finally stopped smoking; correct?
A. What do you mean; how?
Q. How? What he did? How he quit? Excuse me.
A. Well, I know there were multiple attempts and one day he was successful, which is the usual.
Q. But you don't know what he did in order to be successful at quitting; correct?
A. Well, I've dealt with thousands of patients, none of them can tell me why they were finally successful in quitting smoking or cocaine or heroine or anything else. It happens one day.
Q. You don't know what Mr. Kenyon did

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though, to try to quit; correct?
A. No. As far as why he was ultimately successful on that particular day? No.
Q. And you have no knowledge of Mr. Kenyon's smoking patterns; correct?
A. Well, I'm not sure what you mean by smoking pattern.
Q. I mean you don't, for example, whether he smoked the cigarette all the way down to the end or whether he smoked it halfway?
A. That's immaterial. We don't -- I don't go through that detail with any of the thousands of people I see in smoking. We don't usually ask them five hours of questions about the smoking. We just tell them to quit. They try, they can't.
Q. And that's something that's not important to you in forming your opinions in the case; correct?
A. Well, we know from studies that have been done how people smoke. It's not important whether they smoked 21 or 20 cigarettes a day. That is not important. Or if they smoked 90 percent of the cigarette or 91 percent, no, that is not important.
Q. Okay. And here, then am I correct, you

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do not know, for example, whether Mr. Kenyon smoked a light cigarette or an ultra light or full flavored, you don't know anything like that; correct?

A. No. I know he smoke Camel cigarettes and subsequently Salem cigarette.

Q. Do you whether those were full flavor, or light or ultra lights?

A. I don't think that's of significance here.

Q. Do you know whether those cigarettes were filtered or unfiltered?

A. I don't believe that's of major significance, either.

Q. Do you know why Mr. Kenyon chose the particular brands that he chose?

A. I don't know. I don't care. It makes no difference.

Q. So, you formed your opinions in the case without ever having talked to Mr. Kenyon, without ever having read any of the depositions, without ever having talked with any of Mr. Kenyon's doctors, but only person did you talk to was Mr. Acosta, his lawyer; is that correct?

A. I reviewed the records. They were quite adequate. If there were any questions I could

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certainly ask the doctors. There was no need to. I the x-rays were the same whether I review them or the radiologist. The pathology's the same. I would not read 7 hours of testimony about smoking when somebody can relay that to me in an adequate number of words. And I thought I had more than sufficient information. If there was anything else I needed I certainly could ask somebody. I did not see the need for that at all. I had more than ample information here.

Q. And the person who summarized that information to you was Mr. Acosta; correct?

A. No. The only information that I asked Mr. Acosta, as I mentioned, was the smoking history, because I was not going to read 7 hours of depositions about something that I usually ask a patient in a couple of minutes about.

MS. PARKER: Your Honor, I have no further questions at this time.

THE COURT: All right.

Approach, counsel. Excuse me us, for a second, ladies and gentlemen.

(Thereupon, the following discussion was had at the bench out of the hearing of the Jury:)

THE COURT: I've reviewed your motion.

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The -- it appears to me the witness has laid sufficient information to permit him to testify on issues of smoking and to the extent addictions included in that only to the extent it's within his background in treating people as a pulmonologist.

The other issues with regard to this is what in terms of what the -- it goes to the weight. So, I'll deny the Motion in Limine as long as he stays within his pulmonology.

Also he laid sufficient information that he testified sufficiently to establish that he -- he -- he -- he's plenty of chest -- he's reviewed plenty of chest films in his establishment of his medical opinions. I take it that you don't have any CT's or anything.

MR. ACOSTA: I do.

THE COURT: Okay.

MR. ACOSTA: I didn't -- you, you'll have to lay a foundation before you put a CT up there. But I read enough on the plain films. In he's going to -- if he's going to testify from some other plain films you need to lay some kind of foundation. I didn't hear his -- I didn't hear anything other than a

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reference to plain films. Anything else you need, Ms. Parker?

MS. PARKER: Yes, just one thing, I understand, addiction issue clearly it is. Pharmacology, nicotine --

THE COURT: Correct. My ruling is to the extent he strays from his ability to testify with regard to his expertise in pulmonology area, and specifically expertise in treating the patients he sees, that's where his expertise lies. To the extent -- feel free to make an objection to the extent he is straying beyond that. Okay, Mr. Acosta.

MR. ACOSTA: That's fine with me, Judge. I'll be asking some questions --

THE COURT: Well, I mean, if there's other issues, but from what I've got so far that's the -- that's the ruling. You all ask him to speak up when you're talking to him because I don't think the jury's hearing everything that he says.

MS. PARKER: Thank you, Your Honor.

(Thereupon, the bench conference was concluded.)

MR. ACOSTA: Your Honor, in a second I

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would like to approach the clerk and get Exhibit 508, Plaintiffs' Exhibit 508.

Q. Dr. Goldman, would you mind speaking up just a little bit.

A. Sure.

Q. Sometimes we speak softly and it may be difficult for some to hear. And I want to ask you just a few follow up questions relating to those Ms. Parker just asked you. And I want to start out with the field of internal medicine.

Are there sub-specialities within the field of internal medicine?

A. There's about 15 sub-specialties of internal medicine.

Q. Can you give us some sort of idea as to what those are?

A. Sure. There's allergy, there's bone marrow transpontine, there's cardiology, heart disease. In our organization there's dermatology, there's skin diseases, endocrinology, such as diabetes, thyroid diseases. There's gastroenterology, stomach and intestinal diseases. There's hematology, blood diseases. There's infectious diseases. There's what's called medical ethics. There's nephrology, kidney or renal

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diseases. There's occupational medicine. There's oncology. There's pulmonary disease or lung diseases. There's rheumatology or joint, bone diseases. And those would be the major ones.

Q. And you -- you mentioned earlier you're board certified in internal medicine. Could -- as a board certified physician in internal medicine could you then become board certified in these other sub-specialties?

A. Yes. You would take additional training. Medicine -- after you graduate medical school nowadays there's a three year internship and residency. And then you're -- you really studying all of those areas I just mentioned. Then if you wish to become more expert in one of those areas, you would take an additional -- I forgot to mention geriatrics is another -- the elderly.

You would specialize for another one to three years depending on which of those subspecialties you're talking about.

Q. Is pharmacology involved in all of those specialties?

A. Well, pharmacology, anatomy, physiology those are basics in all fields of medicine. You get that really in medical school. It applies equally to

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all of the fields of medicine.
Q. And do you study that?
A. Sure. It's initially you do that for all fields. And then, say in pulmonary disease you would study more pharmacology related to your specific area.
Q. Does pharmacology relate to drugs?
A. Yes. (Nods head)
Q. And drug affects?
A. Yes.
Q. And do you study that in your practice?
A. Oh, sure. It's an ongoing thing. I've also done some research in that particular area.
Q. Now, with respect to all of those subspecialties, do you know any physician that is board certified in every one of those specialities?
A. Well, not to mention psychiatry and pharmacology, no, you -- you -- you can't train for a hundred years, nobody would take 15 tests, nobody in their right mind that's I'm aware of.
Q. Within your area -- you also mentioned acute care. Do you yourself treat patients that have problems that involve all those subspecialties you've mentioned?
A. Pretty much. I mean, I mean some of

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them I may not see except uncommonly or rarely, but pretty much see most of those things.

Q. You mentioned that you see more nicotine addiction than a psychiatrist.

A. Oh, sure.

Q. Why is that?

A. You don't -- I don't know a psychiatrist who even accepts patients for nicotine a -- if I sent a patient for nicotine addiction to our psychiatrist, they wouldn't see them. They would say, well that's not -- we don't do that.

Q. So who --

A. We do that. Generally internist, family practitioners, lung specialists, cardiologists, you know, the physicians who take ongoing care of those patients, that's not the sort of thing that you would send to a psychiatrist, if you will.

Q. Now, within your field, you indicated that you review and are an expert in plain x-ray films?

A. Well, and other radiographs of the chest. I mean, again, a radiologist does 15 organ systems. Doesn't spend his time doing chest radiology. Does barium enemas, bone films, and

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breasts films and so on. And a small part of their -- what they do would be chest radiology. A big part of what I do is chest radiology.

Q. All right. And what kinds of films do you have expertise in reading?

A. Chest x-rays, lung scans, CT scans of the chest. It's not uncommon for a radiologist to ask me to review a film and see what I think of it.

Q. Does that happen to you at USF?

A. Sure, it happens a lot.

Q. Now, in the -- the pathology, can you -- we use the term pathology, what does that mean in lay terms, how would you explain that to the jury?

A. Really there's what's called anatomic and clinical. What we're really talking about here is anatomical pathology, which would be when there's a biopsy, removal or autopsy, where you make up slides of the material and look at it under a microscope. And again, that would include every part of the body, not just the lungs. The lungs would be a small part of what they do. And it's really all I do.

Then there's also what's call clinical pathology, which some pathologists that's almost all they do. Which would be like the blood tests you get

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in the hospital, the laboratory tests, the micro biology and cultures. There's really two separations, anatomic and clinical pathology.

Q. Do you look at these slides under the microscope yourself?

A. Sure.

Q. Did you look at Mr. Kenyon's microscopic slides?

A. Yes.

Q. Now, you were asked about things that you reviewed. I want to show you in evidence Plaintiffs' 508. These are Mr. Kenyon's medical records.

A. Yes.

Q. Did you review all of Mr. Kenyon's medical records?

A. Yes, I did.

Q. Do those medical records contain reference to Mr. Kenyon's history of smoking?

A. Yes. (Nods head)

Q. Do they contain reference to Mr. Kenyon's diagnosis and treatment?

A. Yes, they do.

Q. And you reviewed all of them?

A. This is no different than, you know,

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when I see a patient in the hospital or my office, there's a chart and I review it. I don't go over the x-rays with the radiologist, the pathology with the pathologist, call every treating doctor. I mean, I have to see a certain number of patients. I can't spent ten hours per patient. It would be unnecessary, it wouldn't added anything, it's silly, really. We don't do that. If I have a question, I would then ask somebody if I didn't understand something or had a question, but that's not usually necessary.

Q. Did you have enough information in this case to render an opinion regarding cigarette addiction in Mr. Kenyon?

A. Yes.

Q. Did you have enough information in this case to render an opinion regarding Mr. Kenyon's lung cancer?

A. Sure.

Q. And his emphysema?

A. Yes.

Q. Now, you mentioned that you knew that he smoked Salem and Camel, and said that it -- it was not significant whether he smoked filters or unfiltered, regular cigarettes. Why is it

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insignificant between filters and unfiltered cigarettes in terms of your opinions?

A. Well, a long time ago we used to think and some initial studies even suggested that maybe filtered cigarettes were significantly safer, if you will. But most -- more recent studies have not revealed that, have contradicted that. And most people don't believe there is any major difference in the health effects of the two; filtered and unfiltered. There's apple literature on that and it's very contradictory, which means that it's not, you know, it's not a major effect basically.

Q. Now, with respect to smoking patterns, you were asked a question about that.

Is there any particular reason why a particular person smoking pattern is not significant to you in your opinion?

A. Well, again, it really doesn't matter if you smoked 21 or 20 cigarettes a day or 95 percent of it or '92 percent of it. You know, it's really not of what we call clinical significance. It's not worth investigating or -- or -- or worrying about.

Q. Is nicotine a drug?

A. Sure. Well, it's a pharmacologic substance. We don't usually prescribe it as a drug

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except for certain rare conditions or nicotine replacement.

Q. Right. And nicotine replacement is -- is provided for what reason?

A. Well, usually to try to help with the withdrawal effects when you cease nicotine exposure. There's a variety -- from the addiction there's a variety of withdrawal symptoms. You try to lessen withdrawal symptoms by replacing nicotine. It's not unlike replacing heroin with methadone. It's sort of a similar approach or premise.

Q. Can you draw any similarities between nicotine and any other substances?

A. Well, it's been likened in its addiction to cocaine and heroin. It's felt to be similar in the difficulty of discontinuing it. It's somewhat different in it doesn't have the -- usually the euphoric or intoxicating effects acutely so it's a much more socially acceptable drug, if you will. Smoking than taking cocaine or heroin. But the withdrawal aspects are felt to be not dissimilar.

Q. What kind of withdrawal effects does nicotine cause?

A. Well, I'm sure people know smokers that have gone through that. Craving, they may get very

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anxious. They may get depressed. They may get very lethargic or fatigued. They may get anxiety. They may get insomnia. They may get -- eating a lot more, or gaining a lot of weight. A variety of withdrawal symptoms.

Q. Are those scientifically based?

A. Sure.

Q. Is there a scientific consensus regarding nicotine addiction?

A. Well, every major health organization that I know considers nicotine an addiction; the Surgeon General, the World Health Organization, the AMA. She mentioned the American Psychiatry Association. They consider it an addicting substance. American Psychological Association. The -- I'm not sure what the right term is, but the American Addiction Association or Society considers it an addicting drug. I think every -- I don't know of any major organization, health organization, that considers it not addicting. I'm not aware of any.

Q. And does the addiction interrelate with the smoker's attempt to quit smoking?

A. Well, it makes it very difficult. If you just ask smokers would they like to quit. The vast majority would like to quit. Did they wish they

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never started? The vast majority wish they never started. Have they tried to quit? Many have. Have they been successful? Very few have. Generally ten percent range. It's very difficult to quit even if they have known -- like I see patients with lung disease, like emphysema or lung cancer who are still smoking and I see this all the time and they can't quit even knowing that it's literally killing them. It tells you how strong of an addiction it is.

Q. Is there a test that you have at your clinic that can determine whether or not someone is still smoking?

A. Sure.

Q. Do you find that -- is there -- do you find that people are still smoking -- your patients are still smoking even though they tell you have quit --

MS. PARKER: Objection.

MR. ACOSTA: -- with that test?

THE COURT: Sustained.

BY MR. ACOSTA:

Q. Tell me what you find with respect to this test -- first of all, what is the test to determine whether or not someone is still smoking?

A. We can measure the carbon monoxide in

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the body, either in expired air or in a blood sample, combined with hemoglobin called carboxyhemoglobin, and it tells us if someone recently in the last few hours had smoke inhalation.

Q. Why do you give them that test?

A. Well, we know from -- I know from experience that a lot of times people don't tell us the truth about their smoking history, whether they're embarrassed to tell their physician they didn't quit smoking, or they feel uncomfortable that they can't quit smoking, or for whatever reason. They often say they've quit when they haven't. That's very common; and we've measured that test just as part of an another test, blood gas, and we not uncommonly find that somebody that says they weren't smoking really were still smoking and sometimes quite heavily for the reasons I just mentioned.

Q. Do you have an estimate as to the percentage of how many smokers are addicted to nicotine?

A. Addicted?

Q. Yes.

MS. PARKER: Objection, Your Honor, relevance.

THE COURT: I'll overrule.

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If you know the answer.
THE WITNESS: Well, I think it depends on -- you know, if somebody smokes a cigarette once a week or once a month, I don't think they're addicted. I think if somebody smokes significantly -- and by that, we're probably talking more than five or ten cigarettes a day for weeks -- I think the majority end up as addicted. Probably the 75 to 90 percent range. (Nods head)
Q. Is that -- is there a scientific consensus about that?
A. I believe so, yes.
Q. Is that the scientific consensus?
A. Yes.
Q. Is there a dose relationship between nicotine use and addiction?
A. Well, again, I think that's where we get back to -- if you have a cigarette once a week, you probably aren't getting enough in your system on an ongoing chronic basis to really have an addiction. I think generally that's where the figure of five, maybe ten cigarettes a day and up is a significant dose when continued for weeks or longer that would generally cause addiction.

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Q. Is there any particular way to measure the craving that a smoker has for nicotine?

A. Well, I don't know if an accurate object of measure other than to just talk to them, watch them, and see how they act basically, though often, you know, go to extremes -- I mean, you've been on flights. You've seen and heard people who can't fly two hours without setting off the smoke detector in the bathroom because they can't do without they crave it so much.

Q. Now, with respect to Mr. Kenyon, I asked you to assume that he was anxious and irritable and that he smoked when he got up in the morning and he smoked before he went to bed, that he smoked throughout the day, that he was up to two -- two and a half, three packs a day, had approximately 60 to 120 pack years of cigarette smoking, that he tried to quit, that he tried to quit for at least a day or more on more than one occasion.

Do you have an opinion as to whether or not Mr. Kenyon was addicted to the cigarettes that he smoked?

A. It's a very typical history of an addicted patient, yes. I do think he was.

Q. All right.

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Dr. Goldman, in reviewing the medical records, did you form opinions about his lung cancer and his emphysema?

A. Yes.

Q. All right. I want to show you a record here and ask you a question about it.

A. Okay.

MS. PARKER: Your Honor, may I --

THE COURT: You may.

MR. ACOSTA: I have to wait for my light to warm up --

THE WITNESS: All right.

MR. ACOSTA: -- on my little projector there.

There it goes.

Your Honor, might I move the screen forward? I think -- I can't hardly read those words myself. If I could move it forward maybe three feet, it might help.

THE COURT: All right.

Go over there with Deputy Jones; and you all see if you can move it a little bit.

BY MR. ACOSTA:

Q. This is a report from 5/24/2000.

A. That's the printed date. The report is

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from 5/3/00.
Q. Oh, is it?
A. Yes.
Q. Let me read the Bates number into the record.
A. At the top it gives the date of the exam, I think, on 5/3/00 I saw.
Q. That's Bates number 28557500024. And it's a thorax with contrast. What is -- what is that?
A. It's what's called a chest CT or a computerized tomography. It's a picture of the chest instead of -- in a regular chest x-ray, you shoot the beam this way, and you get a picture in this direction. In this, you kind of slice the chest from the head toward the toe in this direction; and you're looking at those cuts basically.
Q. Is this a computerized type of exam?
A. Well, you know, you do it under a -- a machine, and then a computer generates the images and prints them out.
Q. This -- this sentence right in the middle of the paragraph under Findings it says: "The lung apices demonstrate confluent areas of hyperlucencies compatible with central lobular

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emphysema." What I want to ask you is, first of all, what are the lung apices?

A. The apex is the top. Apices is the plural. So, it would be the tops of both lungs.

Q. And then what does it mean when it says confluent areas of hyperlucencies?

A. Well, "confluent" means together. They're running together. "Hyperlucent" is increased air. There's like destroyed areas of lung where the air sacs are destroyed and coalesce and there's more air in them, and that's consistent with emphysema.

Q. And it says "compatible with central lobular emphysema." What is that?

A. It's a type of emphysema basically, as I just said. It's just one -- there's two types of emphysema, panacinar and central lobular. It's just one type of emphysema.

Q. What is -- what is central lobular emphysema?

A. Well, "emphysema" simply means destruction of lung tissue. It's where -- the lung is usually made up a little alveoli or air sacs, like grape-like structures that contain air. When those walls disrupt, they kind of coalesce into big air sacs or big air spaces. So, it's the destruction of

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the wall of the air spaces. That's emphysema.
Q. Does that affect the functioning of the lung?
A. Yes. It makes it harder to breath. It affects the lung function.
Q. How many patients do you see that have emphysema?
A. Way too many. Through the years I couldn't even guess, but again, thousands.
Q. Is it -- is it -- can you give us a percentage, perhaps, of your patient population that you see?
A. I think it's hard to do. It kind of depends on what rotations I'm on, what hospitals and so on. It's just a very significant amount of any lung physician's practice.
Q. Let me show you another report.
Whoops.
This one is dated April 10, 2000. CT of the thorax, Mr. Kenyon. Bates number 28563500015.
And I want to ask you about this finding here. At the bottom of the paragraph there it says, "There are diffuse interstitial opacities as well as ground glass opacities in the lungs bilaterally, likely chronic and related to chronic

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obstructive pulmonary disease." Could you put that in lay terms for us?

A. Sure. Sometimes with smoking and chronic obstructive lung disease you get inflammation and thickening of the walls of those alveolar sacs, in addition to disruption of them. You get thickening of the small airways where there's inflammation, what we call fibrosis or scarring. So, you see an increase in these what's called diffuse interstitial opacities; and that's very, very common from what we call airway disease that we see in chronic obstructive pulmonary disease.

Q. What does the term "chronic obstructive pulmonary disease" mean?

A. That includes emphysema, chronic bronchitis, and asthma, as well as a rare one that we hardly see any more called bronchiectasis. We hardly see that nowadays.

Q. Now, you've reviewed Mr. Kenyon's chest x-rays yourself?

A. Yes, I have.

Q. Is this a description of -- of any non-smoking-related disease? Well, let me strike it. I'll ask it a different way.

Did you find any -- any asbestosis or

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asbestos-related disease with respect to Mr. Kenyon?
A. No.
Q. What was that?
A. No.
Q. Now, you mentioned that you see a lot of people with emphysema in your practice. Is there a consensus in the medical community as to a common cause of emphysema?
A. Well, the -- the -- by far, the most frequent cause of emphysema is -- is inhalation of tobacco products.
Q. Can a person have emphysema and not know that they have it?
A. Oh, sure. I mean, everything starts in early asymptomatic stages. When it's a small amount of lung and early on, you wouldn't know it. You have so much reserve in your lungs -- there's two lungs. You can even remove a lung or part of a lung and you do fine. So, you could have beginning or early stages and not know it.
Q. And what -- how much lung is destroyed by the time you know it, generally?
A. Well, generally we're talking about close to half or more is generally destroyed before you feel it.

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Q. And once you feel it -- well, let me ask you, when it's destroyed is it -- is it a disease that you can cure?

A. No. Emphysema is -- is destroyed lung. You don't regenerate lung. It doesn't come back. So, when its lost, it's lost. It's lost forever.

Q. Does it generally stay the same, or does it change over time?

A. Well, if somebody discontinues smoking, it -- it -- we all lose lung function as we age. We lose -- we know how much. It's a small amount annually that occurs in everybody after about the age of 18 or 20. If you have emphysema and continue to smoke, you lose it a lot faster; but if you stop smoking, what's lost is lost, but the ongoing loss reverts back to the normal aging loss, if you will.

Q. Now, with respect to determining whether or not somebody has emphysema, aside from seeing changes like those you've just described on the x-rays, are there other ways -- are there other diagnostic tests that need to be performed to determine whether or not someone has emphysema?

A. Well, you may suspect it from listening to the chest with a stethoscope if it's fairly advanced, but you certainly would get what we call

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pulmonary tests, which measure how the lungs work; and we do that in the laboratory, in the office, or in the hospital where we have patients take in deep breaths and blow it out as hard and fast as they can and take some measurements. And those are probably the best tests.

Certainly if you have an a biopsy of the lung or a piece of lung, that's obviously an excellent test.

Q. Can you -- in Mr. Kenyon's case, there was biopsy done for lung cancer.

A. Right, but that was in the airway, not in the alveoli, the area of the lung you have to biopsy. This was more centrally in the airway where the small cell lung cancer was.

Q. Were there pulmonary function studies done from Mr. Kenyon that you reviewed?

A. Yes.

Q. What were they diagnostic of?

A. Well, Mr. Kenyon had more than one problem going on, which makes it more complicated. He didn't have just emphysema or just lung cancer. He had small cell lung cancer. It was being treated with radiation and chemotherapy. The lung cancer was blocking a part of the lung. He had emphysema. So,

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he had -- he was overweight. He had multiple things. So, it's a complicated test.

His pulmonary function tests I thought showed both some restrictions of the amount of air that should be in there from -- from these various factors I've just mentioned, and he didn't get the air out as fast as he should when you're restricted, which indicates the emphysema component of this. So, he had multiple lung diseases going on. His diffusing capacity was also reduced, which is also another very good test of the emphysema.

Q. What is the diffusing capacity?

A. It's a transfer of gases from the air into the -- across the lung surface and into the bloodstream, and we measure by carbon monoxide. We give you a normal amount to breath in, and you breath out the. The difference is what went across into the bloodstream, and that's called the diffusing capacity.

Q. And can you quantify what -- what that meant for Mr. Kenyon, what his diffusing capacity means for him?

A. Again, if just means there's destroyed areas of lung. It's consistent with what we've been talking about.

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Q. Okay. The restrictive component you mentioned, does that have anything to do with destroyed areas of lung?

A. Well, it could. You could certainly get it from that; but here you've also got the lung cancer. You've got blockage of part of the upper lobe of the lung on the right. You've got the fact that he's gotten treatment with radiation and chemotherapy. He's also was overweight. So, you've got a lot of things that could affect the amount of air in the lungs here.

Q. Now, you mentioned that there are things that the physician listens for. Is one of those things decreased breath sounds?

A. Right. When we hear decreased breath sounds, again that's a test suggestive of chronic obstructive pulmonary disease or emphysema.

Q. Now, based on your review of his medical records and your background and training and experience, do you have an opinion as to whether or not Mr. Kenyon suffers from emphysema?

A. I think as shown on the x-ray, on the pulmonary function tests and so on, I believe that he does suffer from emphysema as well.

Q. And do you have an opinion as to what

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the probable cause of his emphysema is?
A. I believe it's secondary related to or caused by his cigarette smoking.
Q. Now, I want to ask you some questions about Mr. Kenyon's lung cancer.
What kind of --
THE COURT: How much longer do you have, Mr. --
MR. ACOSTA: I have probably at least a half hour.
THE COURT: Well, in that case, we're going to take a midmorning break, ladies and gentlemen. We'll take a break for 15 minutes.
(Whereupon, the jury was excused at 10:42 a.m.)
THE COURT: Dr. Goldman, you're in the middle of your testimony, so you can't discuss your testimony with anyone. You're free to get down and take a break.
THE WITNESS: Okay.
THE COURT: We'll be in recess for 15 minutes.
(Thereupon, a recess was had from 10:43 a.m. until 10:57 a.m.)
THE BAILIFF: All rise, court is now

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back in session.
THE COURT: You may be seated.
MS. PARKER: Your Honor, before the jury comes back in.
THE COURT: Yes.
MS. PARKER: I've had a chance to look at the radiology films. And I do have two problems: One, I think we've resolved, there are films of November 6 that I have never seen, our folks have never seen. Mr. Acosta says he will not show those to the witness or jury. I just want to make sure that the witness' testimony is not based on those.
THE COURT: Okay.
MR. ACOSTA: I have no intention of doing that.
THE COURT: All right. So those are not going to be used.
MS. PARKER: And then the second issue, excuse me, Your Honor, I have a case on this, Mr. Acosta has some exemplars, and that is similar x-rays that he's gotten from a book or somewhere. There's a First DCA case that's right on point called Tallahassee Memorial Regional Medical Center vs. Mitchell that says

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that would be improper bolstering. If I could approach. Professor Ehrhardt was involved in the case, I noted.

MR. ACOSTA: Do you have an x-ray copy of that?

MS. PARKER: I sure don't, I didn't know it was going to come up. That's my only copy.

THE COURT: All right. What are you using as your examplar?

MR. ACOSTA: I have a film of a normal chest that -- that Dr. Goldman would use to demonstrative -- just for demonstrative purposes.

THE COURT: Is it from a book?

MR. ACOSTA: No. It's not --

THE COURT: Just a plain chest film?

MR. ACOSTA: It's just a plain chest film that he can testify that it is a normal lung.

MS. PARKER: Your Honor, that would be improper bolstering. He's comparing it.

MR. ACOSTA: It's not from --

THE COURT: I mean, the case says the section does not permit an expert to bolster

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his opinion by showing a medical book to the jury.

MS. PARKER: Well, an x-ray from a book.

THE COURT: And then with the picture of the x-ray in it.

MS. PARKER: I can't imagine why it would be any different whether it was in a book or created separately.

MR. ACOSTA: Well, this would be like a model of a --

THE COURT: Hang on, let me read it.

(Pause)

THE COURT: Well, this -- well, the case is specific -- it appears to me that the case of Tallahassee Memorial vs. Mitchell, 704 So.2d 601, deals with an issue of the use of a medical book for the purpose of in effect violating the evidentiary rule with regard to bolstering an expert's opinion by an authoritative source.

I don't think it applies to the use of a -- this is using a plain chest film. I don't think that case applies to that use of a chest -- plain chest film as a demonstrative

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aid. So I'm going to permit the chest film to be used as a demonstrative aid. But do you need anything else for the record, Ms. Parker?

MS. PARKER: No, sir. Can I go ahead and move around, I can't see the screen?

THE COURT: You can.

MR. ACOSTA: Can I mention one other thing off the record, Your Honor, it's not as to that issue. What we have agreed, I believe, that Dr. Goldman is going to show and describe for the jury some of Mr. Kenyon's x-rays, not all of them, just a few.

These are the original x-rays that are needed out at Moffitt. We've agreed that I will then -- Dr. Goldman brought them. I will give them to Mr. Fuhrman. He will hold them for their -- for use by the defense. And then in the event Moffitt needs them right away for some reason, then I'll call Mr. Fuhrman, and we'll make arrangements to have them out to Moffitt and then back again, so then they'll have control of them so they can use them in their case in chief as they see fit.

In that way they won't actually go into evidence, but I suppose we could -- I will

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identify them by date. If that would be sufficient. However, they want me to do it, I'm willing to do it.

THE COURT: Are they --

MR. ACOSTA: I just want to avoid a problem.

THE COURT: -- you're just using them as a demonstrative aid, you're not going to put them in evidence? You are going to give them to Mr. Fuhrman so their experts can use them if they wish to do so; is that correct?

MR. ACOSTA: That's what I would like to do.

MS. PARKER: That's all correct, with one exception, and that is, we're going to need -- we may already have copies, I don't know, I just need to check. We are going to want to move, I believe -- I can't tell what I'm going to do until Mr. Acosta finishes his case.

THE COURT: Right.

MS. PARKER: We may want to put those -- that radiology in evidence in our case, if so, we'll use the copies that will be fine.

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THE COURT: Make copies, if you make copies of the films.

MS. PARKER: That ought to solve the problem.

MR. ACOSTA: I guess --

THE COURT: If somebody wants them in the record, they just need to make a copy for the record.

MR. ACOSTA: I just want to avoid an unfair argument, something like, well, Mr. Acosta didn't put the x-rays into evidence, but here the defense is as if I'm hiding something, which I -- we can avoid, but that's --

THE COURT: You can put them -- you can put them into evidence too. The plain chest film can't come into evidence because it's --

MR. ACOSTA: Right.

THE COURT: -- it's not Mr. Kenyon's. But Mr. Kenyon's x-rays can be admitted into evidence if you choose to do so, and I believe they do make copies of x-rays.

MR. ACOSTA: All right, we'll just --

THE COURT: All right. Let's get the jury in here and continue.

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And Ms. Parker -- go ahead and get the jury.

Cross an hour?

MS. PARKER: I think it's longer than that.

THE COURT: Okay. When I get -- when we -- we'll let Mr. Acosta finish up. I'll start your cross. Somewhere a little after noon, go to about -- somewhere between 12 and 12:10 figure a good place to stop.

MS. PARKER: I'll just say, Your Honor we're at a good place to break or something like that.

THE COURT: Right.

MS. PARKER: Thank you, Your Honor.

THE COURT: And then this afternoon we'll have -- conclude you, Dr. Goldman. And then we will have what, Mr. Kenyon back --

MR. ACOSTA: (Nods head)

THE COURT: -- for completion? And that will probably take us through most of today. We need to stop today at somewhere between 4 and 4:30, one of the jurors has an appointment.

MR. ACOSTA: Okay.

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(Pause)
THE BAILIFF: All rise.
(Thereupon, the jury returned at 11:05 a.m.)
THE COURT: You may be seated.
All right, Mr. Acosta.
MR. ACOSTA: Thank you, Your Honor.
BY MR. ACOSTA:
Q. Dr. Goldman, what kind of -- of lung cancer does Mr. Kenyon have?
A. He has a type that we call small cell lung cancer.
Q. Is -- have you had experience with small cell lung cancer?
A. Extensive experience, yes.
Q. And how common is it in your clinics?
A. Well, all lung cancers are common, but that's a fairly common type of lung cancer we see an awful lot of it.
Q. Has the commonality of lung cancer among patients changed over the years?
A. Well, it's a very common disease. We hope it's going to start coming down as hopefully less smoking, but it's a very common disease. I believe there are about 170,000 cases a year.

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Q. Of lung cases?
A. Right.
Q. How frequently is lung cancer a fatal disease?
A. Well, taking all cases of lung cancer, it's felt to be fatal in all cases. Probably, approximately 90 percent of the time.
Q. And what distinguishes Mr. Kenyon's small cell lung cancer from the other types?
A. Well, each type has suggestive clinical radiographic and then most importantly pathologic features under the microscope. Small cell lung cancer is extremely rare in non-smokers. It's almost always in a smoker -- cigarette smoker.
It's often a very fast growing tumor. It has certain features radiographically, as far as being predominantly what we call central tumor with adenopathy, involvement of the lymph nodes and of the chest and the mediastinum. It is tends to be subdivided into limited, which is in the chest and extensive, which means its metastasized or spread outside the chest.
Most cases of small cell are metastatic rather than limited. The metastatic kind is -- you may get an initial response to chemotherapy and

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radiation, but it's almost always fatal. Even in the limited kind most cases are fatal. Even if they apparently respond initially to therapy.

Q. Now, do you care for and treat patients with small cell lung cancer?

A. Yes, less so now. I started the lung cancer program at Moffitt Cancer Center. I originated it, and ran it for a number of years when I was there. And now with other duties I don't do that any more. But I did for a long time and saw a large number of patients. Now I see fewer, but still see several.

Q. Can you give us an estimate as to what percentage of all lung cancers are small cell lung cancer?

A. Well, I think it varies. It's more common in heavily smoking males. Probably 25, 30 percent range, but it would vary from place to place, and depending on the population.

Q. Now, can you give the jury an estimate as to how many small cell lung cancer cases you have seen over the years?

A. Well, I'd say over 30 years I would venture to say I've seen thousands of cases.

Q. Have you ever seen a case in a

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non-smoker?
A. Not that I recall. I mean, occasional cases where I heard somebody say they thought they had a case. But even though you don't -- we've already said, people don't always give you an accurate smoking history, you really have to talk to family, friends, acquaintances to verify the smoking history. Or even measure the carbon monoxide levels we've talked about. I don't think I've seen any in non-smoker. There may be a very rare case of that possibly.
Q. Now, is there a scientific consensus about the relationship between cigarette smoking and the cause of small cell lung cancer?
A. Yes.
Q. What is that?
A. As we just said, it's very heavily related to smoking. It's questionable if there are any cases not due to cigarette smoking.
Q. Now earlier in your testimony you talked about not knowing the mechanism. How can you know the cause of a disease without knowing the mechanism?
A. When I say mechanism, I'm talking about cellular or molecular level. We don't know that for

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almost any disease. There are very few diseases that we know that. We don't know that for heart disease or cancers or diabetes or high blood pressure. We just know what, you know, it's related to. What causes it and all. We don't know what change occurs at what cell that necessarily causes most diseases. I don't know if we ever will.

Q. How is it that you are able to determine then that cigarettes are a cause of lung cancer?

A. Well, we know that, as we just said, a small cell lung cancer you essentially don't see it in non-smokers, number one. You can look at how consistent the data is and there are several studies that repeatedly show the same thing, how strong the so called dose response relationship is if you take people who hardly smoke and all the way up to heavy smokers for some years to many years, and you see a -- what we call dose response effect.

You see a reducing in the response, but not an elimination of it. And people who have been long time quitters, for example, you certainly have studies where you can look at progressive changes in the cells of the lungs that we can sample with -- with smoking. A list of variety of various

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techniques that tell you that.

Q. With respect to other factors other than smoking, are there any other known factors that cause small cell lung cancer other than smoking?

A. Well, I don't know if they cause it by themselves. They would increase the frequency in smokers. For example, radiation uranium miners, may be high doses of radon in other areas of the country than here.

So radiation, certain chemicals, even asbestos in heavy smokers in high doses where there's asbestosis, all those things would make it more frequent or more common in smokers.

Conversely if you just had those exposures without smoking, you still would -- don't see small cell lung cancer. Non-smoking groups with those sorts of exposures.

Q. Assuming that you had exposures to these other things and you were smoking, can you compare the two in terms of causing the cancer? Smoking versus the other things that might cause it?

A. Yeah, the way you compare that is look at the two separately and then together. Let's say radiation, smoking or uranium miners smokers, like I said, if you just have non-smoking exposure you still

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don't see small cell lung cancers. If you have just smoking without the other exposure, you have a lot of smell cell lung cancer.

If smoking and the other exposure, you have even more. So you don't get it without the smoking, but you certainly get it more in smokers who also have some other exposures.

Q. And with respect to Mr. Kenyon's medical records, there in front of you, did you see any risk factors for small cell lung cancer for him other than cigarette smoking?

A. No.

Q. Now, you mentioned dose response. What is a significant dose of cigarette smoking in terms of its cause and effect with relationship to cancer of the lung?

A. Well, it's probably a continuum, but at low doses it's uncommon. In fact, that's the whole basis, I'm sure people read about environmental tobacco smoke. Smoking on airplanes or in restaurants, because it isn't publicly safe. It doesn't mean it's as bad as smoking two packs of cigarettes a day.

But there are environmental tobacco smoke cases of -- excess cases of lung cancer. So

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even at these lower doses there's a rare to occasional case of lung cancer caused by that. Certainly not anywhere near the frequency of the problem of a heavy smoker, for example, but not zero.

Q. What -- what about one pack a day?

A. That's a heavy -- a heavy dose. One pack a day, you know, for ten years is considered a pretty hefty dose. 20 years or two packs a day is heftier dose and so it goes up and up.

Q. How about three quarters of a pack a day?

A. I think again if it was one day or whatever, it's a light dose. If it's 20 years, it's a pretty hefty dose.

Q. Ten cigarettes a day?

A. Again, then you would have to say is it one day of ten cigarettes or 40 years. There's a big difference.

Q. Now, if you stopped smoking what happens to your risk?

A. Well, the risk comes down for say, heart attacks pretty immediately. For lung cancer it starts to come down and it -- it comes down, we used to think years ago that it came way down, unfortunately, more recent studies show that it comes

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down but not way down. So it's still a substantial risk, many, many years later.

Q. What in your opinion is that risk in terms of someone that -- that smoked and then quit for ten, 20, 30 years, 40 years?

A. Well, I think it also depends on how much they smoked. What age they started at. There's a lot of factors. There's a large -- a fairly large VA study that was done a few years back that I recall where risk still stayed up many, many years later, about 50 percent of what it was. So it's way up, and not -- not as bad as it was, but not back to nothing or even low.

Q. All right. And do some people that quit ten, 20, 30, 40 years ago still get lung cancer from cigarette smoking even though they quit a long time ago?

A. I think if I recall correctly in that VA study, people who had quit up to 40 years ago, still had a fairly high incidence of lung cancer that approached almost half of what it was.

Q. With respect to Mr. Kenyon's smoking, did he have a sufficient dose to cause his lung cancer?

A. Certainly. Yes.

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Q. Now, are you familiar with the term "latency?"
A. Yes.
Q. What does that mean?
A. Well, it means between the -- whatever happened and the manifestation of the disease is a latent period or length of time. Not unlike planting a seed under the ground and not seeing the tree for months or a year or having a baby or something like that.
It's most with inhalation exposures like asbestos, even if you are exposed to asbestos today in massive amounts for the next -- you know, year or years, you wouldn't expect to see any disease caused by that for, you know, 15, 20, 30 years, or 40 years later. It's the same with smoking. You wouldn't smoke a cigarette today and have a lung cancer tomorrow. It doesn't work that way. There's a period of time involved. And that's called a latent period.
Q. How long -- what is the range of that in terms of what probably occurs to most people?
A. I think in general the latent period is felt to be somewhere at least eight to ten years, possibly even longer.

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Q. And --
A. Before you start to see problems and then it goes on, as I said, 20, 30, 40 years.
Q. Now with respect to Mr. Kenyon, did he have cancer in his lung back in 1982?
A. No. He didn't.
Q. Does that mean anything to you? Is that significant to you in terms of cigarettes being or not being a cause of his lung cancer?
A. No. No.
Q. How about if he didn't have lung -- did he have lung cancer in his lungs in 1992?
A. Well, I don't think with the small cell lung cancer that it would be silent in the lungs for any extended period of time, so I would say no, he didn't.
Q. The fact that he didn't have cancer in his lungs in 92 or '82 does that have any bigger on the causal relationship between his smoking and the lung cancer?
A. No, not at all.
Q. Now, the fact that he may have quit in 1982 or 1992, some eight to -- to 18 or 19 years before he got lung cancer, his risks would have gone down; is that accurate?

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A. Right.
Q. Does the fact that his risk went down have anything to do with whether or not cigarettes caused his lung cancer?
A. No, he still at higher risk -- much higher risk than a non-smoker. Not as high as if he continued to smoke two packs a day. But unfortunately for him still high enough that he got it.
Q. Now, you have -- did you review some -- some x-rays of Mr. Kenyon's chest with respect to his lung cancer?
A. Yes, I did.
Q. All right. Can I ask Dr. Goldman to come down?
THE COURT: You may. You may come down.
MS. PARKER: Your Honor, may we approach?
THE COURT: Before he does that?
MS. PARKER: Then I'll move down.
THE COURT: And you may move around. Excuse us.
(Thereupon, the following discussion was had at the bench out of the hearing of the

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Jury:)

MS. PARKER: Your Honor, I have a different objection.

THE COURT: Uh-huh. (Indicating affirmatively)

MS. PARKER: And that is in discovery, when I took his deposition, and the answer, I don't have anything else. Can you compare them to anything --

THE COURT: Well, here's the thing, a demonstrative -- normally, I don't think any of the pretrial orders covered demonstrative aids, do they, specifically?

MS. PARKER: In discovery it does. I asked him, is there anything that he is using that I know is not covered in that deposition.

THE COURT REPORTER: I can't hear.

THE COURT: Try to speak in here.

Why don't you say that again, Ms. Parker.

MS. PARKER: Sure.

I object to Mr. Acosta using examplars with this witness because it was not provided to us in discovery, despite my having asked repeatedly when I took his deposition and in

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letters to Mr. Acosta before. And the Court has all already entered one order saying that he couldn't enter studies for that same reason.

THE COURT: What --

MS. PARKER: While he asking the questions --

MR. ACOSTA: This is different. And I don't -- I don't even use the term "examplar". This is simply a demonstrative aid.

THE COURT: Well --

MR. ACOSTA: That is not required to be --

THE COURT: If the request -- if there was a specific request as to what was going to be used, then --

MR. ACOSTA: Judge, I don't even -- I don't remember if there was -- I don't think there was a specific --

MS. PARKER: I can --

MR. ACOSTA: Wait a minute, excuse me. I don't think there was a specific request, but even so, I'm not marking this as an exhibit.

THE COURT: I understand.

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MR. ACOSTA: And it's simply demonstrative.
THE COURT: It's not the point --
MR. ACOSTA: And I wouldn't have known back then if they asked me -- if they sent me discovery, that's a different thing. I can't anticipate every single thing that a witness might need to demonstrate something to a jury. This is --
MS. PARKER: May I continue on with the deposition?
THE COURT: Wait. Hang on. Go ahead.
MR. ACOSTA: This is not something that is a surprise to Reynolds because --
MS. PARKER: It certainly is.
MR. ACOSTA: -- this same film was used in the Jones case with Ms. Parker was right there. The exact same one.
THE COURT: Well, this is -- we're not -- this is --
MR. ACOSTA: I mean --
THE COURT: This is this case, that was that case.
MR. ACOSTA: They're trying to suggest --

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THE COURT: The fact that something was used in another case is not persuasive to the Court.

All right. We can either take a break and look through what was specifically asked at the deposition or you can proceed and have him testify about Mr. Kenyon's x-rays. And then -- and then at the conclusion of that we'll just review it over the -- at the lunch break.

MR. ACOSTA: I want to use it and I want them to show me what they specifically asked for.

THE COURT: That's fine.

MR. ACOSTA: Until I see it, I can't accept it.

THE COURT: All right.

(Thereupon, the bench conference was concluded.)

THE COURT: We're going to be more than a couple of minutes.

Kenny. If you all wouldn't mind going back into the jury room for just about five minutes and we'll get you right back out.

Grab what you need and then come back

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up here.
(Whereupon, the jury was excused at 11:25 a.m.)
(Pause)
MS. PARKER: I have my part. I just need to put my hands on the other.
THE COURT: Go ahead.
(Pause)
MS. PARKER: All right, Your Honor, I have it, I believe.
THE COURT: Come on and approach the bench.
(Thereupon, the following discussion was had at the bench out of the hearing of the Jury:)
MS. PARKER: Okay. Here's our interrogatory. "Please identify" -- number 8. "Please identify any and all documents or exhibits intended to be used by plaintiffs at trial. And for each document or exhibit, please state the name," et cetera, et cetera.
He says he'll put it on the exhibit list and this is not on the exhibit list. And we described -- we define documents at the beginning as everything.

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THE COURT: All right.

MS. PARKER: We also sent a subpoena for his deposition. And we asked here "For all other documents, literature and/or data relied upon by Dr. Goldman to form his opinions relating to this case." And we asked for everything there. He didn't bring it. And then here's the transcript --

THE COURT: This one wouldn't apply because this specifically refers to items relating to his opinion of this case. I don't think that would encompass a plane chest film. That's what this is. I don't believe that language would be sufficient.

MS. PARKER: Okay. I need not show you the deposition then where he said that was it?

THE COURT: No.

MS. PARKER: It was just that.

THE COURT: All right.

MS. PARKER: Thank you.

THE COURT: Let me just see how it was defined.

What's the -- do you have definitions in here?

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MS. PARKER: Yes.
MR. ACOSTA: This --
THE COURT: Do you have --
MS. PARKER: We have it here.
MR. ACOSTA: Judge, I have never been bound by a definitional section of a set of interrogatories; ever. Ever before.
THE COURT: I'm just going to read it, Mr. Acosta. See what they ask.
MR. ACOSTA: The rules don't provide for any definitions.
THE COURT: Let me read it.
MR. ACOSTA: All right.
THE COURT: When I get it, I'll read it.
(Pause)
You guys got --
MS. PARKER: Your Honor, we don't have what we sent with us. I can get it over lunch.
THE COURT: Interrogatory. "Please identify any and all documents" --
(Pause)
All right. This inquiry and this response would not limit the plaintiffs in

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using a plane chest -- a plane chest film as a demonstrative aid because what I read here is you asked for any and all documents or exhibits intended to be used at trial. And it -- and this suggestion was the following: Exhibit list, but it -- but I don't -- when I read the term, and I haven't seen your definitions, but when I read the term, "any and all documents or exhibits," I think the proper interpretation is an identification of what is to be marked and entered into evidence.

MS. PARKER: Can we -- get it brought over during lunch?

THE COURT: You can bring it back over during lunch. I'm going to let the plaintiff proceed with the testimony at this point. I'll just --

MS. PARKER: Unring bell?

THE COURT: Well, I don't see -- here -- you know, I don't -- plane chest film is not in the -- you know, I haven't seen the specific plane chest film, but if it's like every other plane chest film or if it's similar to all other plane chest films, it

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does not -- it is not a -- it is not an exhibit of such -- it's not a demonstrative aid of such, that creates an issue -- a significant issue that's prejudicial to either side because, frankly, all it does is establish a baseline from which then an explanation can be given of Mr. Kenyon's. And I think the same is true when your medical experts testify, they may or may not rely on demonstrative aids that establish some kind of baseline so that they can then explain Mr. Kenyon.

So I don't find it -- you know, I don't think of a -- I don't see how a plane chest film would be prejudicial in that regard. Unlike, if a demonstrative aid was coming in which Mr. -- which would suggest that we had did an autopsy on this patient and this is what -- this is what -- this was his autopsy finding, this is what his chest film showed, and then try to compare to what Mr. Kenyon, I think that would create a different and prejudicial situation. So --

MS. PARKER: I understand your ruling.

THE COURT: -- we'll go ahead and

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proceed.
MR. ACOSTA: Thank you.
MS. PARKER: I can still bring it over after lunch for the record.
THE COURT: Yes.
MS. PARKER: All right, thank you.
THE COURT: All right.
(Thereupon, the bench conference was concluded.)
MS. PARKER: Your Honor, may I move?
THE COURT: Yes, Ms. Parker.
Ms. Parker, to see this, you may want to get over here. Wait until the jury comes in.
(Thereupon, the jury returned at 11:35 a.m.)
THE COURT: All right. You may be seated. And, Ms. Parker, you can --
MR. ACOSTA: Might we approach one second?
Can we approach for one second?
THE COURT: Okay. Okay.
(Thereupon, the following bench conference was had:)
MR. ACOSTA: I just want to ask if Your

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Honor might ask the jury, if they would like to scoot down so they can all see it.

THE COURT: Well, I'll just tell them if they can't see, they can move.

Do you have your notes?

MS. PARKER: I don't need them.

THE COURT: Okay.

(Whereupon, the bench conference was concluded.)

THE COURT: All right.

Doctor, you may step down.

Ladies and gentlemen, if for some reason you can't see the film box, feel free to scoot down and/or raise your hand and we'll let you all re-arrange.

And, Dr. Goldman, make sure all the jurors can see you as you explain.

All right, Mr. Acosta, go ahead and inquire.

MR. ACOSTA: May I trade places here?

THE COURT: Sure.

BY MR. ACOSTA:

Q. Dr. Goldman, would you briefly tell the jury what that film is?

A. This is what's called a plane x-ray of

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the chest.

Let me take a minute or two, this is how we explain to our medical students and residents; to shoot an x-ray, there's an x-ray machine that shoots a beam of x-rays; and you stand between the machine, and there's a picture plate there.

And if -- if you didn't stand there and nothing absorbed the x-ray, everything would be black. So, outside the person, where there is just air, you have black.

Then if you put something in the way of that, depending on how dense it is, it absorbs that x-ray beam.

So if you put like lead or something, it would absorb all that beam, and it would be white.

So tissue appears white and air appears black. So you can see, here's the chest, and this structure in the middle is the heart. And since there's no air in the heart, it absorbs the x-rays and it looks white.

These are diaphragms which separate the heart and the lungs from the abdomen. And so this would be the abdominal contents down here.

Up here we have these white structures going across are the ribs, 12 on each side. Your

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clavicles. And then the black is really the air in the lung tissue. And that's what you're seeing.

And this is a -- what's called a standard film from the International Labor Organization, INO film, that enables you to compare other films against it, really for comparison purposes.

So, this is a normal film with a normal heart, normal diaphragms, normal ribs, normal amount of air in the lung. Really no abnormal structures. This is really a normal view for -- for comparison purposes.

If you then --

Q. Would you compare Mr. Kenyon's?

A. If we look at Mr. Kenyon's film from -- and this is -- this is a film from May 25th, 2000, that we can just put up next to it.

And I'm just going to show you the -- the larger abnormalities here. This is what's called the highland or the -- where the blood vessels and the air tubes that go to the right lung and to the left lung form.

And in that area over here on the right lung we see an increase in that shadow there. We also see some thickening of this tissue along the

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chest wall laterally.

Here we don't see normally. And that, you know, relates to his diseases or problems. We see the same thing on the other side.

This is a film taken after he's already been started on his -- his therapy, his treatments for his lung cancer.

If you look at that, and in comparison to a more recent chest x-ray from -- this is May of 2000 -- this doesn't stay up very well. You may need to hold that.

Q. This is the standard?

A. This is May of 2001.

I think you can -- even though you're not radiologists or lung specialists, I can direct your attention to the right lower chest here; and you can see that the amount of air in this lung here was like that. Now the amount of air is much less.

What's happening is -- this is what's called pleural fluid, fluid around the lung, that's accumulating into the chest, and taking up the bottom part of the lung. So there's just less.

You can see the amount of air on the left to the right; much less on the right. And the bottom of the right lung is much higher than on the

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left because of what we call pleural effusion or fluid around the lung.

And there's a lot of scarring of lung tissue here where he had his radiation therapy. His radiation kills the tumor. It also, unfortunately, damages adjacent good lung as well. It scars it down.

And these are just plane chest x-rays showing between May 2000 and May 2001, the development of this fairly sizable -- what we call right pleural effusion there.

There's some CAT scans -- I don't know if we --

Q. Let me ask you first about the --

A. Oh.

Q. -- about the August chest film, and then --

MS. PARKER: Your Honor, if I could, as we discussed earlier, if Mr. Acosta could identify each one of those films by number, for the record.

MR. ACOSTA: Yes, I'll be happy to do that.

THE COURT: Go ahead, Mr. Acosta.

MR. ACOSTA: Yes, Your Honor.

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The first film is -- got a number on it that's 22,000 7500. It also has also has a number 05.25.2000, 10/2, that's the date, I believe.

And then the next film that we viewed was -- it has the same 22,000 7500 on it. It's 5/29/2001, at 12:52.

The first film had the number 58 in the right-hand corner of the reference area. And the second has a number 258. Third film we're going to review has a DX number, 200100005208. It's dated 8/13/2001 at 14.4.

THE WITNESS: I think if you look at -- this is now August of 2001, versus we have May, 2001. And I think you can appreciate, again, the -- this fluid in the right bottom chest is continuing to increase. There's even less air on the right than there was just -- what we call pleural effusion in there.

BY MR. ACOSTA:

Q. What causes that pleural effusion?

A. Well, it can be many causes. In this situation you are -- it's related to the cancer of the lung. It's developed after the treatment that is increasing.

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Q. Here we have the CT scan dated --
MS. PARKER: Your Honor, excuse me.
JUROR #1: Doctor, are those frontal views?
THE WITNESS: Yes. It's actually what's called a PA or posterior/anterior view, which would be the frontal view.
JUROR #1: So, when we're looking at it we're actually looking at the front?
THE WITNESS: Yes. The right lung is actually -- let's put that up for a second.
The -- the heart is in the middle. It's as if the patient is facing you. So the right is actually on this side and the left would be over here.
JUROR #1: (Nods head)
THE WITNESS: And the top, the bottom, the right, left, frontal view.
JUROR #1: (Nods head)
THE WITNESS: That's in contrast to the CT where we cut this way. Instead of shooting a picture in this direction, we're actually shooting it from your head down and taking little cuts like a loaf of bread. And you are slicing down from the top down.

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This -- this is just for demonstration purposes. Here's a nice film.

Now, as I said, as you're cutting the person from the top down, so it's a cross-section of the chest. And it's as if they're lying with their feet facing you and their head facing me, and that's how you do it. Lying down on the table, somebody may have had a CAT scan. Then the machine makes these cuts. And so this is the back of the person.

You can see the vertebrae back here. These are the vertebral bodies. This is the front up here; the back down here. So these are the vertebral bodies.

And as you get down, you get into the heart. And what you can see here is, again, this is the right side, the left side, the right lung, the left lung. You can see that you have a lot of fluid on the right lung. And you just have black or air in the left lung.

And, in fact, when you go and you look at this, you also see a little -- I don't know how well you can appreciate this, there's a

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little lump right here, a little nodule or mass projecting out right there, which can be very obvious, what is that, is that related to the cancer? And you say, it may well be.

This is what's called a CAT scan. Again, just gives you a better feel for what's going on. It's a little better picture than an x-ray. Usually a little more detail of what's going on here.

BY MR. ACOSTA:

Q. Was there any change in that lump that you saw from a prior CT scan?

A. Well, this effusion or fluid around the lung was new and this lump was new, which again is very obvious.

Q. Is there any other film you want to show?

A. No, I think -- we could go through hundreds of films there, but I think these show the basics.

Q. All right, thank you, doctor.

MS. PARKER: Could we identify that film?

THE COURT: It was the last film put up.

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MR. ACOSTA: This is the CT from 31, July, 2001. And I believe the window the doctor was pointing to as -- it's 2IMA13.

THE COURT: All right. Are you finished using the view box?

MR. ACOSTA: Yes.

THE COURT: Just turn it off and put it on the floor.

Thank you.

BY MR. ACOSTA:

Q. Now, Dr. Goldman, can you tell the jury what the significance of the pleural effusions are with respect to Mr. Kenyon?

A. Well, there's a lot of causes of pleural effusion, but a very common one is a cancer of the lung. And unfortunately when there is a pleural effusion associated with the lung cancer, it's an ominous finding. It's a -- not good for a good prognosis. Implies that the tumor is progressing and outside of the area of our control basically.

Q. Up through September 20th, of this year, from the time he was diagnosed up through September 20th, the records indicate that he had two thoracentesis; is that accurate?

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A. Yes.
Q. What's is a thoracentesis, briefly?
A. Well, we can take a little needle, numb the skin with Novocaine, like a dentist. And numb between the ribs and you can take a needle and syringe and put it in to where that fluid is, and suction out that fluid. And then run various laboratory tests on that fluid, look at the fluid under a microscope to try to see what's causing the effusion.
Q. Is the fact that he had two of those from the time of his initial diagnosis up through September 20th of any significance?
A. The fluid comes back. So again, it's an ongoing issue, an ongoing problem. It's actually increasing. So again, that's not a good finding.
Q. What is your prognosis? What do you see the future for Mr. Kenyon to be based on what you saw through September 20th?
A. I'd be quite concerned.
Q. Is he going to have a need for future medical care?
A. Oh, sure. He still has fluid in there. It's increasing. I believe he's still seeing his multiple physicians there. And he will need to

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continue to do so.
Q. How long is he going to need to have future medical care for his lung cancer and emphysema?
A. The rest of his life.
Q. And I think at one point we talked about radiation. Did he have radiation to his brain?
A. Yes.
Q. What -- what is the purpose of that?
A. Well, with small cell lung cancer, unless it's a little tiny nodule where you remove it surgically, in all other cases it's more advanced and so the treatment is drugs or chemotherapy where you inject medicine in the vein and it's supposed to go everywhere. There's what's called a blood vein barrier. Those chemicals or drugs don't get into the brain tissue. So if you have small metastasis or spread of tumor to the brain, in fact too small to recognize on x-rays or scans, the chemotherapy won't go there. And we know that occurs in roughly 10 or 20 percent of patients with small cell lung cancer. And the only test you can do would be to cut their brain open, which is kind of a rash test, so that we just assume it may be there and in 10, 20 percent of the cases. And the drugs aren't going to kill it so

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we radiate the brain to kill off those tumor cells in the head. Some people call it that prophylactic brain radiation. But it's actually meant to kill off small metastases that occur at that point in point. But there's no easy way to tell who does or doesn't have that.

Q. Is it an appropriate thing to do?

A. Yeah, it's pretty standard. Some -- every few years we evaluate whether to do it or not. Some people -- it used to be routine and done in every case. Now it's done a little more selectively because there are side affects of radiating -- if --

MS. PARKER: Objection, Your Honor.

THE WITNESS: -- only 10 or 20 percent --

MS. PARKER: Objection, Your Honor.

May we approach?

THE COURT: Well, let me just sustain and go ahead.

MS. PARKER: Thank you.

THE COURT: Be responsive directly to Mr. Acosta's question.

THE WITNESS: What I'm trying to explain --

BY MR. ACOSTA:

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Q. Typically are there consequences to brain radiation?
A. Sure.
Q. What are they?
MS. PARKER: Objection.
MR. ACOSTA: In general?
THE COURT: Just excuse us, approach for a second.
(Thereupon, the following discussion was had at the bench out of the hearing of the Jury:)
THE COURT: I haven't heard anything that qualifies him to testify about the effects of the brain radiation. He's a pulmonologist. The witness yesterday testified --
MR. ACOSTA: Well, I know he knows about -- this is his --
THE COURT: I have not heard anything. So if you want to lay a foundation for it.
MR. ACOSTA: Okay.
THE COURT: You may try, but I have not heard anything.
MS. PARKER: If I could just add this. In his deposition he said -- cites in here he

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knows absolutely nothing with regard to this issue with respect to Mr. Kenyon.

MR. ACOSTA: I know.

MS. PARKER: True.

MR. ACOSTA: It's not even in. It's long --

THE COURT: All I'm saying is I haven't heard anything. I have not heard anything. If you want to lay a foundation. If you'll try to do that, and I'll let Ms. Parker voir dire if she wants to do that on this issue.

MR. ACOSTA: Well, I'm not going to relate it directly to Mr. Kenyon, only the treatment.

THE COURT: I understand. But he's a pulmonologist, he's not an oncologist.

MR. ACOSTA: All right.

THE COURT: He's not a neurologist.

MR. ACOSTA: Okay. I know, but he's chief over it all.

THE COURT: No. He's the chief of internal medicine. Doesn't mean he's an expert in internal medicine -- every field of internal medicine.

(Thereupon, the bench conference was

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concluded.)
BY MR. ACOSTA:
Q. Dr. Goldman, are you familiar with the effects of brain radiation on the patients?
A. Sure. Cared for thousands of patients who had radiated or had radiated their brains.
Q. You do you ever recommend that treatment for your patients?
A. Sure.
Q. And is it something that you've been trained in determining what effects that brain radiation might have on them?
A. Sure.
Q. Do you counsel them about what it is?
A. Yes.
Q. Do you tell them what the risks are and so forth of brain radiation?
A. I do. And then our radiation therapist repeat it as well.
Q. You don't have an opinion about what the effect of brain radiation on Mr. Kenyon was in this case, do you?
A. No. Just in talking about why -- I thought the question was why you radiate the brain. You know -- what happens.

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Q. All right. In general, though, when you tell your patients what the risks of radiation are, what do you tell them?
A. Well, when you radiate any tissue, when you're trying to kill off abnormal cells, you also kill off some normal cells. So whether it's the lung or the brain, when we radiate the brain, we're going to lose some mental function as a process of that. That's an accepted consequence when you're trying to kill off cancer cells.
Q. Now I think I just have maybe one or two final questions.
Is it your opinion that his emphysema has been caused by his cigarette smoking?
A. Yes.
Q. And does that cause him to be impaired in terms of his breathing?
A. Yes.
Q. Does that aggravate his lung cancer?
A. Well, it aggravates the impairment of his lung function, part of which is from the lung cancer and part of which is from the emphysema.
Q. And does the lung cancer aggravate his emphysema?
A. Same as we just side.

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Q. Are they two separate diseases?
A. Yes.
Q. Independent of one another?
A. Yes.
Q. With respect to the lung cancer, do you have an opinion as to a probability as to whether Mr. Kenyon's cigarette smoking caused his lung cancer?
A. Yes.
Q. What is your opinion?
A. Well, almost one hundred percent certainty, pretty close to one hundred percent.
MR. ACOSTA: Thank you. That's all I have, doctor. Thank you.
THE COURT: All right, thank you Mr. Acosta. Ladies and gentlemen, it is five to 12, so why don't we take our lunch break and we will see you back at 1:30. Ms. Parker will start her cross at that time.
MS. PARKER: Thank you, Your Honor.
(Whereupon, the Jury was excused at 11:55 a.m.)
THE COURT: Dr. Goldman, you are in the middle of your testimony, so you'll need to be back here at 1:30 to complete your testimony.

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However, do not discuss your testimony with anyone. Thank you, sir.

You're free to step down at this point.

Just counsel approach and we'll be in recess shortly.

Did you ever look at the designations yet to see if you have objections to that?

MS. PARKER: Mr. Fuhrman --

MR. ACOSTA: I had Bruce Denson do that and I need to call him up.

THE COURT: Did you all want to object to their designations?

MR. FUHRMAN: Yes, sir. I have not had a chance --

THE COURT: So you're planning to do that?

MR. FUHRMAN: I'm going to have to go through and do that. But they have not designated any for their case.

THE COURT: They never --

MR. FUHRMAN: That's only if ours -- if they don't have anything they want --

MR. ACOSTA: I'm not sure about that. That's not the way we normally do it.

THE COURT: Well, in your case in

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chief, my understanding that you have designations.

MR. ACOSTA: Well, I thought we did. That's why I need to talk to Mr. Denson, because we --

THE COURT: If you want to put something in your case in chief you needed to have designated --

MR. ACOSTA: I know, I thought he did. That's what I'm getting at.

MR. FUHRMAN: At the beginning, they objected to the entirety of Ms. Vandy.

THE COURT: All right. Here's -- Let's do it this way. I haven't looked at that decision. All right, let me just tell you all. If they need -- I don't know why either side needs that deposition, because the exhibit's in evidence. And because -- Vandy is an employee of the life insurance --

MR. FUHRMAN: Correct.

THE COURT: -- company. And then you've asked a variety of questions as to what this application says. All of which are, you know, you could put -- I mean, you've got it in evidence, you can put all -- that is

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already in evidence. So that's my question.
MR. FUHRMAN: I agree with that one hundred percent. There's one extra step that Ms. Vandy takes on that issue, what's not in the insurance company's records, there's no amendment, no correction, no change to the application. And Mr. Kenyon testified in his deposition when asked about the application, the fact that he said he hadn't smoked in the prior 20 months. He said that was a quote unquote amendable statement. Ms. Vandy gets us to the point that Mr. Kenyon never did that --
THE COURT: She can testify as a records custodian that there were no amendments.
MR. FUHRMAN: She does.
THE COURT: But that's all we need out of that. Because the rest of it is just; what does the ap say and what doesn't it say.
MR. FUHRMAN: We can --
MR. ACOSTA: There's no amendment, Judge. He wasn't using that term amendable in that context.
THE COURT: It doesn't matter. I mean,

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all I'm saying is this is a records custodian. On file there's been no amendments to it. I think that's the only relevant portion I heard testimony. You know, we can -- I can let in the whole thing, but it's not relevant.

MR. ACOSTA: I agree.

THE COURT: Because -- because all the questions of what the ap says and that's it. So, it's in her file. There's no -- on the record custodian in her files, no amendments, just read -- cut that depo down so it's basically doing that.

MR. FUHRMAN: Yes, sir.

THE COURT: On the other two, I have got, I'll do them later. But basically I see no foundation laid that it was friable asbestos in this building, okay. If there is no -- in your asbestos, I need to -- somebody needs to testify it was friable asbestos. The fact that the building has capsulated -- capsulated materials asbestos is not sufficient. Okay.

MR. FUHRMAN: Okay.

THE COURT: Foundation. So, that would not normally come in. None of the statements

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smoking will come -- would come in. And then what the investigators do with -- with Reynolds, wouldn't come in, because it's not relevant to anything. The rest of it comes in. I've got -- I can go through page by page over the break.

MR. FUHRMAN: Your Honor, might I respond to that?

THE COURT: Yeah.

MR. FUHRMAN: For Mr. Habich and Mr. McPartlin I think I think short circuit this. The only thing we designated was the asbestos issues. So if we can't show that it's friable it doesn't come in, I think that those two would go away in their entirety. They only have counter designations if we don't play anything, I -- my --

THE COURT: There was some other designations about; did you see him smoke?

MR. FUHRMAN: That was by them, they didn't designate anything in their case.

MS. PARKER: Only designated about five or six lines.

THE COURT: All right. Well, the fry -- here's the thing, on those depositions

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you have to lay a deposition it was friable asbestos. If there's some friable asbestos then it certainly can -- could come in, but you have to reach that.

MR. ACOSTA: Judge, they have to go further than that. They have not disclosed any expert. That will say that asbestos had any affect on Mr. Kenyon.

THE COURT: I don't know if they have any experts that say it's friable.

MR. ACOSTA: Even if they did they won't be able to show it is from a --

THE COURT: Well, it's a separate issue, just for the foundation.

MS. PARKER: We're just --

MR. FUHRMAN: We'll pull those two depositions.

THE COURT: All right. So that takes care of that. So then the only one left at this point is Fife and Vandy to the extent. Look back -- I know you all -- they've identified, you've identified stuff of Vandy. But it's, you know, it could be -- I mean it could be Kenny taking the stand and having it in front of him and testify; yeah, it says

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this, it doesn't say that, because she has no personal knowledge.

MR. ACOSTA: I agree one hundred percent.

MR. FUHRMAN: Your Honor, my recollection --

THE COURT: Let the record -- basically she can testify, I have the file. But I have perhaps no amendments in the file. That's --

MR. FUHRMAN: We'll cut it down to that.

THE COURT: Okay.

MR. ACOSTA: Can I just see what you do before you do it?

THE COURT: Yeah. I'm just saying re --

MR. FUHRMAN: Your Honor --

THE COURT: Reverify.

MR. FUHRMAN: I don't know -- Since they're going to try and say Jeanne Fife in their case, could I have maybe until after the Thanksgiving break to get my objections?

THE COURT: That's fine. I just wanted to find out if you had that issue with what -- how many -- I haven't started looking at Fife.

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Who is Fife?
MR. FUHRMAN: Mr. Kenyon's sister, older sister.
THE COURT: The one in Texas? That's fine. Just wait.
MR. FUHRMAN: I will --
THE COURT: We've taken care of that one. Your letter.
MR. ACOSTA: Letter.
THE COURT: Exhibit, the one --
MR. ACOSTA: Yes, sir, 219.
THE COURT: Plaintiff referred, 219. If -- if -- it was not a statement made to the general public, so in his case in chief I'm not going to allow it.
On rebuttal, if Reynolds takes the position contrary to any of the statements in that letter, okay, it will come in on -- on plaintiffs' rebuttal case.
MS. PARKER: But only in redacted form.
THE COURT: Right.
But if you -- if Reynolds takes -- there's a variety of statements made that actually are -- frankly are duplicates of some evidence that you already have in. But if

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Reynolds take the position as of the date of that letter something that contrary to a statement in that letter, it will come in in the rebuttal case.

MR. ACOSTA: Yes, sir.

THE COURT: Okay. In your case in chief -- because -- because it was not a statement what was disseminated to the general public, a statement directly to a specific individual. I'm not going to allow it in in the case in chief.

MR. FUHRMAN: Yes, sir.

MS. PARKER: Thank you, Your Honor.

THE COURT: I think that covers all of it right now.

MR. ACOSTA: I have another document that I'm going to move into evidence.

THE COURT: That's fine. You haven't given that to me yet, right?

MR. ACOSTA: Can I give it to you? It's short.

THE COURT: Just when we get back from lunch. Just -- get a copy of it for me, give it to me when we get back from lunch.

MR. ACOSTA: Okay. Okay.

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THE COURT: Or some break.
MR. ACOSTA: Okay. Thanks, Judge.
MS. PARKER: Thank you, Your Honor.
THE COURT: All right. Court's in recess until 1:30.
(Thereupon, court was recessed at 12:07 p.m.)

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COURT REPORTER'S CERTIFICATE

STATE OF FLORIDA)
CIRCUIT OF HILLSBOROUGH)

I, MARY ELIZABETH BLAZER, Court Reporter for the 13th Judicial Circuit of the State of Florida, in and for Hillsborough County,

DO HEREBY CERTIFY that I was authorized to and did report in shorthand the proceedings and evidence in the above-styled cause, as stated in the caption hereto, and that the foregoing pages numbered 1183 to 1306, inclusive, constitute a true and correct transcription of my shorthand report of said proceedings and evidence.

Dated this 20th day of November, 2001.

_____
Mary Elizabeth Blazer, RPR

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